STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Comparative Federal Life Safety Code (LSC) Survey was conducted on July 15, 2014. It was conducted as per the requirements of the Federal Register at 42CFR 483.70 (a) using the existing Health Care Section of the 2000 edition of the LSC and its referenced publications. It is of Type II (111) single story. It was fully sprinklered and certified 60 beds. Census was 32.	K 000	Disclaimer Submission of this response and plan of correction is not A legal admission that deficiency exists or that this statement of deficiencies was correctly cited, and is also not to be construed as an admission of interest against the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain doors that were free of impediments to closing.	K 018	K018 SS=D Life safety code standards Facility ensures that there is no impediment to the closing of the doors in accordance with NFPA 101. POC ACCEPTED AUG 11 2014 B.C 8-2014 8-15-14 Per phone with maintenance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 8/4/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 Finding include: On July 15, 2014, a door stop was found in the Employee Lounge on the floor by the door. This was verified with the Director of Maintenance, at the time of discovery. Ref: 2000 NFPA 101 Section 19.3.6.3.3 Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Failure to maintain doors that were free of impediments to closing increases the risk of death or injury due to smoke and/or fire. The deficiency affects 1 of 5 smoke compartments.	K 018	**Residents Affected/Potentially Affected by the Cited Deficient Practice:** No specific residents were identified. **Identification of Other Residents Potentially Affected:** No Resident residing in the facility would have the potential to be affected by this alleged deficient practice **Measures/Systemic Changes Implemented:** Audit doors to ensure the are no objects keeping doors from being free or impediments to closing. weekly X4 then monthly x2 by Maintenance Director Education to staff on using Objects to prop open doors. **Monitoring:** These findings will be presented in the monthly Quality Assurance Committee bimonthly x4 months which is attended by the Executive Director, Director of Nursing, Medical director, Social Services, Activity Director to determine compliance. 8-15-14 Per phone with maintenance	